CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

_____
(Date)

MEMORANDUM

TO: Local Office
Department for Community Based Services
Cabinet for Families & Children

FROM: _____ Provider #: _____
(Facility/Waiver Agency)

SUBJECT: _____
(Recipient Name) (Social Security/Medicaid Number)

_____
(Previous Address)

_____
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced recipient

☐ was admitted to this facility/waiver agency _____
(Date)
is in Title _____ Payment Status, and was placed in a
(XVIII or XIX)

☐ NF bed ☐ ICF/MR/DD bed ☐ MH bed ☐ EPSDT Bed

☐ Home & Community Based Waiver Service ☐ SCL Waiver Service and/or

☐ was discharged from this facility/waiver agency on _____
(Date)
and went to _____,
(Home Address/Name & Address of New Facility/Waiver Agency)
and/or expired on _____.
(Date)

☐ was re-instated to Home & Community Based or SCL waiver services within 60 days of the NF admission. _____
(Date Re-Instated)

For Home & Community Based waiver Clients only – last date service was provided _____.
(Date)

_____
(Signature)

MAP-24 (Rev. 02/2001)